



# Idaho Supplemental Small Group Employee Enrollment/Change Form Aetna Life Insurance Company

### A. Employer information

Employer company name	Group number/control number (if a current Aetna customer)
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### B. Enrollment information

Effective date	Employee name	Social Security number
Work address		
Date of birth	Date of hire	Salary \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly
Enrollment – Check all that apply <input type="checkbox"/> New group enrollment <input type="checkbox"/> New hire <input type="checkbox"/> Late enrollee <input type="checkbox"/> Other _____		

### C. Coverage selection

Control/Group number	Suffix	Account	Plan number
<b>1. Dental – Check applicable boxes.</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child <b>Non-voluntary plans:</b> <input type="checkbox"/> Aetna Dental® Plan – Plan option _____ <b>Voluntary plans:</b> <input type="checkbox"/> Aetna Dental® Plan – Plan option _____ <p style="text-align: center;"><b>Before today, were you covered under this employer’s dental plan?</b>    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> Creditable coverage is allowed for new members enrolling in voluntary takeover groups. New hires please see below if applicable: New Hires selecting a Voluntary plan <b>and your Aetna plan is a takeover group:</b> Were you covered for 12 months under a dental plan within the last 90 days that included both Preventive and Basic coverage? Discount dental and preventive-only plans do not apply. <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>Aetna Life Insurance Company underwrites Aetna dental plans.</i>			

Control/Group number	Suffix	Account	Plan number
<b>2. Vision (if applicable) Check applicable boxes.</b> <input type="checkbox"/> Employee <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic partner <input type="checkbox"/> Child <b>Aetna Vision<sup>SM</sup> Preferred</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Aetna Life Insurance Company underwrites Aetna vision plans. First American Administrators, Inc. provides certain claims administration services. EyeMed Vision Care, LLC (“EyeMed”) provides certain network administration services.</i>			

### D. Changes – Check all that apply.

	Name	Date of birth	Social Security number	Date of event	Reason
<input type="checkbox"/>	Add spouse*				
<input type="checkbox"/>	Add domestic partner*				
<input type="checkbox"/>	Add child*				
<input type="checkbox"/>	Name change				
<input type="checkbox"/>	Change plan				
<input type="checkbox"/>	Other				

\*Employee must be enrolled for spouse/domestic partner and dependents to enroll for coverage.

**E. Remove or terminate – Check all that apply.**

	Date of event	Reason
<input type="checkbox"/> Employee termination		
<input type="checkbox"/> Remove spouse		
<input type="checkbox"/> Remove domestic partner		
<input type="checkbox"/> Remove child	Name	
<input type="checkbox"/> Cancel coverage		

**F. Dependent information**

List any dependent in Section D living at another address.	
Name	Address

**Conditions of enrollment**

I understand that the following legal entities underwrite the plans I apply for:

- Aetna Life Insurance Company underwrites Aetna dental plans and Aetna vision plans.

1. My employer's application determines coverage. I don't have coverage until Aetna approves my employee enrollment form and the employer application. Even if Aetna approves the employer application, any misstatements or omissions may result in denial of future claims. Aetna may rescind or reevaluate my coverage under the policy, as of the effective date, for eligibility and rating purposes. If Aetna voids or rescinds coverage, I may be entitled to a refund of any paid premiums from the effective date of coverage. Aetna will give at least 30 days advance written notice to any covered person affected by the proposed rescission. If I elect to receive electronic notifications, I will receive this notice in an electronic (email) format.
2. To underwrite the coverages listed on this enrollment, Aetna may need information about medical history, services or treatment provided to anyone listed on this form. This may include information about mental health, substance use disorder and HIV / AIDS. I authorize that the following entities can provide this information to Aetna or its agents:
  - Physicians
  - Other healthcare professionals
  - Hospitals
  - Other healthcare organizations ("providers"), including
    - Pharmacies
    - Pharmacy database benefit managers
3. I authorize Aetna to use and disclose such information to:
  - Affiliates
  - Providers
  - Other insurers
  - Third party administration
  - Vendors
  - Consultants
  - Governmental authorities with jurisdiction when necessary for:
    - Care or treatment
    - Payment for services
    - Operation of my health plan
    - Conduct related activities

*Continued on next page*

**Conditions of enrollment (Continued)**

4. I discussed the terms of this authorization with my competent adult dependents. They agreed to these terms. This authorization is valid for 30 months from the signature date. This authorization is valid for the term of the coverage for medical information collected in connection with a medical claim. This authorization is voluntary. But if I don't sign this form, my ability to enroll in the plan may be affected. I have the right to revoke this authorization in writing to Aetna at any time. I can't revoke authorization for information already used or disclosed before I revoked my authorization. I am entitled to receive a copy of this authorization upon request. A photocopy is as valid as the original.
- The Group Agreement / Group Policy determines the rights and responsibilities of members and will govern in the event they conflict with any:
    - Benefits comparison
    - Summary
    - Other description of the plan
  - Participating physicians, hospitals and other health care providers are independent contractors. They are not Aetna agents or employees. We cannot guarantee the availability of any particular provider. Any provider network is subject to change. We will provide a notice of the change in accordance with applicable state law.
5. I authorize the substitution of generic pharmaceuticals for the brand-name products, as provided by law, for prescriptions filled under any pharmacy benefit.

I represent that all information supplied in this form is true and complete. I have read and agree to the conditions of enrollment and misrepresentation section on this **Idaho** Supplemental Employee Enrollment / Change Form. I understand that, if I don't sign this form within 31 days or Aetna does not receive the request within a reasonable time, my eligibility may be affected. I am working full-time at least 30 hours a week (or 20 hours a week if my employer extends coverage) for this employer at the regular place of business. I authorize deductions from my earnings for any premium contributions required for coverage and I agree to make any necessary payments as required for coverage.

**Misrepresentation:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**The dental certificate provides dental benefits only. Review your dental certificate carefully.**  
**The vision certificate provides vision benefits only. Review your vision certificate carefully.**

To receive documents online, please visit your secure member account at [aetna.com](http://aetna.com).

<i>Employee signature</i>	<i>Employee email</i>	<i>Date (Month/Day/Year)</i>
<b>X</b>		